

# DENTAL HISTORY

\*Name:

\*What is the main reason for your visit today?

\*When was your last dental exam?

\*How do you feel about the condition of your mouth?

If not, what would you improve?

\*Does the thought of dental care make you nervous?      Yes      No

If yes, what is the most bothersome?

\*Previous Dentist's Name:

Why did you leave your former dentist?

\*How often do you?

A. Have dental examinations and cleaning?

B. Brush your teeth?

C. Floss your teeth?

\*What other dental aids do you use? (Interplak, toothpick, etc.)

**Are your teeth sensitive to:**

Hot or Cold?      Yes      No

Sweets?      Yes      No

Biting or Chewing?      Yes      No

Do you ever have mouth odor or bad taste?      Yes      No

Do you tend to get cold sores or fever blisters?      Yes      No

**Do your gums bleed or hurt:**

Have your parents experienced gum disease or tooth loss?      Yes      No

Have you noticed any loose teeth or change in your bite?      Yes      No

Does food tend to get caught between your teeth?      Yes      No

If yes, where?

**Do You:**

Clench or grind your teeth?      Yes      No

While asleep or awake?

Bite/chew your lips or cheeks?      Yes      No

Hold foreign objects with your teeth? (pen, fingernails, pipe)      Yes      No

Mouth breathe while asleep or awake?      Yes      No

Smoke/chew tobacco?      Yes      No

**Have you ever had:**

Orthodontic treatment?      Yes      No

Oral surgery?      Yes      No

Periodontal treatment?      Yes      No

Bite adjustment?      Yes      No

Serious injury to the mouth or head?      Yes      No

If yes, please describe:

**Have you ever experienced:**

Clicking or popping of your jaw?      Yes      No

Pain? (joint, ear, face)      Yes      No

Difficulty in chewing?      Yes      No

Headaches/neck aches?      Yes      No

Are you satisfied with the appearance of your teeth?      Yes      No

Do you expect to keep your teeth all of your life?      Yes      No

Have you ever had an upsetting dental experiences?      Yes      No

If so, please describe

Is there anything else about having dental treatment that you would like us to know?  
Yes      No

If yes, please explain: